(4) If the M+C organization does not provide or arrange for the service consistent with HCFA's NCD, enrollees may obtain the services through qualified providers not under contract to the M+C organization, and the organization will pay for the services consistent with § 422.109(c).

(5) Beneficiaries are liable for Part A deductible and any applicable coinsurance amounts.

(c) The term ''significant cost'' as it relates to a particular NCD means either of the following:

(1) The average cost of furnishing a single service exceeds a cost threshold that—

(i) For calendar years 1998 and 1999, is $100,000;

(ii) For calendar year 2000 and subsequent calendar years, is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage described in § 422.254(b).

(2) The estimated cost of all of Medicare services furnished nationwide as a result of a particular NCD represents at least 0.1 percent of the national standardized annual capitation rate (see § 422.254(f)), multiplied by the total number of Medicare beneficiaries nationwide for the applicable calendar year.

§ 422.110 Discrimination against beneficiaries prohibited.

(a) *General prohibition.* Except as provided in paragraph (b) of this section, an M+C organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an M+C plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

(1) Medical condition, including mental as well as physical illness.

(2) Claims experience.

(3) Receipt of health care.

(4) Medical history.

(5) Genetic information.

(6) Evidence of insurability, including conditions arising out of acts of domestic violence.

(7) Disability.

(b) *Exception.* An M+C organization may not enroll an individual who has been medically determined to have end-stage renal disease. However, an enrollee who develops end-stage renal disease while enrolled in a particular M+C organization may not be disenrolled for that reason. An individual who is an enrollee of a particular M+C organization, and resides in the M+C plan service area at the time he or she first becomes M+C eligible, is considered to be ''enrolled'' in the M+C organization for purposes of the preceding sentence.

(c) Plans are required to observe the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, and Americans with Disabilities Act (see § 422.502(h)).

[63 FR 35077, June 26, 1998; 63 FR 52612, Oct. 1, 1998; 64 FR 7980, Feb. 17, 1999]

§ 422.111 Disclosure requirements.

(a) *Detailed description of plan provisions.* An M+C organization must disclose the information specified in § 422.64 and in paragraph (b) of this section—

(1) To each enrollee electing an M+C plan it offers;

(2) In clear, accurate, and standardized form; and

(3) At the time of enrollment and at least annually thereafter.

(b) *Content of plan description.* The description must include the following information:

(1) *Service area.* The M+C plan's service area and any enrollment continuation area.

(2) *Benefits.* The benefits offered under the plan, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and for purposes of comparison—

(i) The benefits offered under original Medicare, including the content specified in § 422.64(c);

(ii) For an M+C MSA plan, the benefits under other types of M+C plans; and

(iii) The availability of the Medicare hospice option and any approved hospices in the service area, including those the M+C organization owns, controls, or has a financial interest in.

(3) *Access.* The number, mix, and distribution (addresses) of providers from

whom enrollees may obtain services; any out-of network coverage; any point-of-service option, including the supplemental premium for that option; and how the M+C organization meets the requirements of §§422.112 and 422.114 for access to services offered under the plan.

(4) *Out-of-area coverage.* Out-of-area coverage provided by the plan.

(5) *Emergency coverage.* Coverage of emergency services, including—

(i) Explanation of what constitutes an emergency, referencing the definitions of emergency services and emergency medical condition at §422.2;

(ii) The appropriate use of emergency services, stating that prior authorization cannot be required;

(iii) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; and

(iv) The locations where emergency care can be obtained and other locations at which contracting physicians and hospitals provide emergency services and post-stabilization care included in the M+C plan.

(6) *Supplemental benefits.* Any mandatory or optional supplemental benefits and the premium for those benefits.

(7) *Prior authorization and review rules.* Prior authorization rules and other review requirements that must be met in order to ensure payment for the services. The M+C organization must instruct enrollees that, in cases where noncontracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the M+C organization for processing and determination of enrollee liability, if any.

(8) *Grievance and appeals procedures.* All grievance and appeals rights and procedures.

(9) *Quality assurance program.* A description of the quality assurance program required under §422.152.

(10) *Disenrollment rights and responsibilities.*

(c) *Disclosure upon request.* Upon request of an individual eligible to elect an M+C plan, an M+C organization must provide to the individual the following information:

(1) The information required under §422.64(c).

(2) The procedures the organization uses to control utilization of services and expenditures.

(3) The number of disputes, and the disposition in the aggregate, in a manner and form described by the Secretary. Such disputes shall be categorized as

(i) Grievances according to §422.564; and

(ii) Appeals according to §422.578 et. seq.

(4) A summary description of the method of compensation for physicians.

(5) Financial condition of the M+C organization, including the most recently audited information regarding, at least, a description of the financial condition of the M+C organization offering the plan.

(d) *Changes in rules.* If an M+C organization intends to change its rules for an M+C plan, it must:

(1) Submit the changes for HCFA review under the procedures of §422.80.

(2) For changes that take effect on January 1, notify all enrollees by the previous October 15.

(3) For all other changes, notify all enrollees at least 30 days before the intended effective date of the changes.

(e) *Changes to provider network.* The M+C organization must make a good faith effort to provide written notice of a termination of a contracted provider within 15 working days of receipt or issuance of a notice of termination, as described in §422.204(c)(4), to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must also be notified.

[63 FR 35077, June 26, 1998, as amended at 64 FR 7980, Feb. 17, 1999]

§422.112 Access to services.

(a) *Rules for coordinated care plans and network M+C MSA plans.* An M+C organization that offers an M+C coordinated care plan or network M+C MSA plan may specify the networks of providers from whom enrollees may obtain